AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (select one below)

❑ **Zyflo®** (zileuton)	❑ **zileuton extended-release**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Maximum Quantity Limit: 600mg daily; 4 tablets per day

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member must be 12 years of age or older;

AND

- ❑ Member must have a confirmed diagnosis of asthma;

AND

(Continued on next page)

- ❑ Member must have trial and failure of a combination inhaled corticosteroid/long-acting beta-2 agonist product (e.g. Symbicort, Advair) for **at least 3 months** **(chart notes documenting therapy failures must be submitted)**

AND

- ❑ Member must have a **30-day trial and failure** of **BOTH** montelukast **AND** zafirlukast **(chart notes documenting therapy failures must be submitted)**

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

*****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****